

# **Exhibit H**



Deposition of:  
**Stephen B. Levine , MD**

*September 10, 2021*

In the Matter of:  
**Kadel, et al vs. Folwell**

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IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

~~~~~

MAXWELL KADEL, et al.,

Plaintiffs,

vs. Case No. 1:19-cv-272-LCB-LPA

DALE FOLWELL, in his official  
capacity as State Treasurer of  
North Carolina, et al.,

Defendants.

~~~~~

Video Deposition of  
STEPHEN B. LEVINE, M.D.

September 10, 2021  
9:05 a.m.

Taken at:  
Veritext Legal Solutions  
1100 Superior Avenue  
Cleveland, Ohio

Tracy Morse, RPR

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1           Q.     Okay. And so then were there any  
2 external grants to research and publish about  
3 the treatment of children or adolescents --

4           A.     No.

5           Q.     -- with gender dysphoria?

6           Okay. Is that a, "No," when I included  
7 the, "Gender dysphoria," as well?

8           A.     That is a, no.

9           Q.     Okay. Thank you. Okay. So on  
10 page 3 of your report -- actually, I'm sorry.  
11 It's going to be the bottom of page 4 and to  
12 the top of page 5. Your report lists your  
13 experience as an expert witness, which we  
14 talked about a little bit earlier. I just --  
15 I'm wondering if you would confirm this is not  
16 an exhaustive list of your experience as an  
17 expert witness either via deposition or report.

18          A.     I wouldn't want to testify that  
19 this is absolutely complete, given the fact  
20 that I don't keep a list compiled. This is  
21 kind of compiled retrospectively from memory  
22 and documents. And so this is the best I could  
23 have done on April of 2021 --

24          Q.     Understood. Thank you. So --

25          A.     -- you might find something else.

1 Q. Was it --

2 A. -- in a commercial building where  
3 our clinic was. It was just, you know, a  
4 conference room in our clinic.

5 Q. And that was within -- was that  
6 within a business --

7 A. It was --

8 Q. -- a psychiatric practice?

9 A. I'm sorry. I interrupted you.

10 It was within The Center For Marital  
11 Health, which was a business that I and two  
12 other people started and owned and ran. And in  
13 that business, we continued the same kind of  
14 work we did with the University minus the large  
15 number of trainees.

16 Q. You mentioned that after '93, you  
17 were not being paid by the University. Were  
18 you providing your clinical psychiatric  
19 professorship gratuitously?

20 A. Meaning without pay? Yes.

21 Q. Okay. Do you know if, after you  
22 moved the clinic away from Case Western  
23 Reserve, if Case Western Reserve University  
24 Medical School created a separate gender  
25 identity clinic?

1           A.     Years later they did --

2           Q.     Oh, sorry.

3           A.     -- I would say, they created a  
4     separate clinic perhaps in 2017, 2016.

5           Q.     Do you know the name of that  
6     clinic?

7           A.     I don't think it's in the  
8     department of psychiatry. I think it's in the  
9     department of pediatrics. And the answer to  
10    your question is, no.

11          Q.     Does The LGBTQ and Gender Care  
12    Program sound familiar?

13          A.     No.

14          Q.     But have you -- sorry. Have you  
15    evaluated any patients through that separate  
16    clinic that Case Western Reserve has?

17          A.     No. Much to my dismay, that clinic  
18    was formed and maintained without any input  
19    from me, who I thought was one of the experts  
20    in the field.

21          Q.     Do you know if they have  
22    psychiatrists, within that clinic?

23          A.     I -- I'm not knowledgeable about  
24    the composition of that clinic. There is a  
25    very strong liaison between our department of

1           What do you mean by, "This era"?

2                   A.       Before 1993.

3                   Q.       Okay. And what do you mean by,  
4           "Occasional"?

5                   A.       I would say that 95 percent of the  
6           patients that we saw were 16 and 17, 18 and up.  
7           We could debate what the word, "Child," means,  
8           but to me an 11-year-old is a child, even  
9           a 13-year-old is a child, especially when my  
10          children were 13. And so we -- in the first  
11          twenty years, transgender issues were primarily  
12          an older teenager and adult, mostly adult  
13          issues. In recent years, I would say, 12, 15  
14          years, the number of adolescents appearing in  
15          gender clinics at our place and everywhere as  
16          far as I can see has increased exponentially,  
17          especially the number of teenage girls who are  
18          declaring themselves trans boys.

19                  Q.       So how many -- sorry. So the first  
20          twenty or so years, you said approximately 5  
21          percent of all patients were children.

22                  A.       Were younger -- on the younger end  
23          of the spectrum --

24                  Q.       Right.

25                  A.       -- yes.

1       it, you see? But at this moment -- this week,  
2       I have one patient that I see weekly, who is a  
3       transgender teen. My staff -- if I can be  
4       presumptuous to call them, "My staff" -- our  
5       staff sees more.

6               Q.       And thinking about the last year,  
7       approximately how many adult patients did you  
8       see -- and let's use your framing of,  
9       "Regular." So that could be one, for one  
10      followup visit or that could be for more -- how  
11      many adult patients did you see for treatment  
12      of gender dysphoria?

13             A.       Approximately six.

14             Q.       And using that same framing of,  
15      "Regular," how many children, so under age 11?

16             A.       In the last year?

17             Q.       Yes, yes. In the last year.

18             A.       Zero.

19             Q.       How many adolescents in regular  
20      treatment for gender dysphoria would you  
21      approximate you've seen in the last five years  
22      individually, exclusive of your supervision of  
23      other clinicians?

24             A.       If you ask me the question in the  
25      last year, I would have told you five or six,

1 but since you ask it as a five-year period, I'm  
2 at a loss to tell you whether it's twelve or  
3 fifteen. I --

4 Q. An approximate is fine. Thank you.

5 A. -- let's just say a dozen with an  
6 asterisk, very approximate.

7 Q. And jumping a little bit more in  
8 terms of time. How about the last ten years?

9 A. Again, using the same asterisk, I  
10 would say, double it.

11 Q. Okay. And you said zero people  
12 under age 11, so children this last year. What  
13 about in the last five years?

14 A. Oh, two years ago, we had this  
15 charming little 6-year-old. One of my  
16 colleagues specializes in children and I get to  
17 hear about these cases. Occasionally I get to  
18 meet the parents, but I personally have not  
19 delivered a psychotherapeutic care or  
20 evaluation directly of a child with the  
21 exception of this one person that I was  
22 involved with.

23 Q. And that was this last year, you  
24 said?

25 A. That was -- I think it was probably

1 two, two and a half years ago.

2 Q. Oh, okay. And what kind of  
3 treatment -- I should say, have you referred  
4 any of those adolescent patients for additional  
5 treatment, besides psychotherapy, for the  
6 treatment of gender dysphoria?

7 A. Yes.

8 Q. And what kinds of treatment have  
9 you referred them for?

10 A. For endocrine treatment.

11 Q. Okay. And approximately what  
12 percentage of those adolescent patients have  
13 you referred for endocrine treatment?

14 A. Give me the timeframe of that  
15 question, please.

16 Q. Sure. So you said a few moments  
17 ago, in the last five years, you saw maybe,  
18 asterisk, 12 to 15 adolescent individually  
19 yourself. Of those 12 to 15, what would be the  
20 approximate percentage you referred for  
21 endocrine treatment?

22 A. I'm hesitating to answer the  
23 question, because some of those children have  
24 been taking testosterone or estrogen  
25 surreptitiously from their parents. And while

1 I didn't refer them for the treatment, I was  
2 seeing them while they were taking the  
3 treatment. So if we're only talking about  
4 adolescent -- referrals of adolescents for  
5 hormones, I would say a very small percentage  
6 of those, say, I guess you would say 10  
7 percent.

8 Q. Fair enough. Have you had yourself  
9 individually as a clinician, have you had any  
10 non-transgender children who you have made a  
11 referral for endocrine treatments related to  
12 other conditions?

13 A. No.

14 Q. Okay. So then zooming out 30,000  
15 foot view of your 48-year career now, would you  
16 say overall, you have provided treatment --  
17 that is, psychiatric treatment -- to mostly  
18 adults experiencing gender dysphoria, gender  
19 identity issues?

20 MR. KNEPPER: Objection, form.

21 A. I would say that throughout my  
22 career, we should divide my career into the  
23 first twenty years where mostly adults were  
24 seen by our team and myself. And then we ought  
25 to talk about the last ten or fifteen years

1 where the number of adults has diminished and  
2 the number of adolescents has increased  
3 dramatically.

4 Q. Okay. Thank you. So as a part of  
5 your private practice, do you write letters of  
6 authorization for endocrine treatments?

7 A. Yes.

8 Q. And do you write letters of  
9 authorization for gender affirming surgeries?

10 A. I have. I have not recently,  
11 because most of my patients are 13 or 15 or 16,  
12 you know.

13 Q. Okay. And I'm sorry. Just by,  
14 "Recent," when was the last time you wrote a  
15 letter of authorization for a gender affirming  
16 surgery for an adult?

17 A. Probably twelve months ago.

18 Q. Okay. And over the course of your  
19 career focusing on your treatment of adults  
20 experiencing gender identity issues, for what  
21 percentage of those patients would you estimate  
22 you wrote a letter of authorization for gender  
23 affirming surgery for?

24 MR. KNEPPER: Objection, form.

25 A. Again, I would like to put an

1        asterisk to whatever I answer this question as.  
2        I have not kept track of those figures. I have  
3        written -- I've written or cosigned letters for  
4        hormone treatments and for gender confirming  
5        surgeries for many people. There were more  
6        people in the '70s and '80s than in recent  
7        decades. In part as a reflection of my own  
8        evolution of understanding of these problems  
9        and in part it's a reflection of the demography  
10       of patients who are coming to see me. I really  
11       would not like to answer that question, only  
12       because I don't know if the word, "Fifteen," or  
13       the word, "Twenty-five," or the word,  
14       "Thirty-five," is more accurate --

15                Q.        Understood.

16                A.        -- but I can tell you, I have  
17        written letters, especially in the early years,  
18        for the things that you're making reference to.

19                        - - - - -

20                        (Thereupon, Deposition Exhibit 2,  
21                        12/21/2020 Zoom Deposition of  
22                        Stephen B. Levine, M.D., was marked  
23                        for purposes of identification.)

24                        - - - - -

25                Q.        Okay. For the record, I'm showing

1           Q.     Do you think as a general matter  
2     that it's good for patients who come to DELR  
3     for services related to gender dysphoria to be  
4     able to have insurance coverage of that care?

5           MR. KNEPPER:   Objection, form.  
6     Beyond the scope.

7           A.     Well, the people who come to DELR  
8     are generally coming for evaluation and  
9     psychotherapy services. And I believe it's  
10    very important that people have access to  
11    mental health care and that mental health care  
12    for many of our patients are not wealthy,  
13    affluent people. And the fees that even  
14    masters prepared people charge can become  
15    prohibitive. And so I think it's a very nice  
16    idea, the psychiatric services, mental health  
17    services evaluation and ongoing treatments,  
18    with or without medication, it would be nice to  
19    be able to cover those things, yes. I think  
20    that's a long answer, yes.

21          Q.     Understood. And thinking about the  
22    treatment that you refer patients out for, the  
23    endocrine treatments in particular, do you  
24    think it is generally good if you provide  
25    authorization for that treatment that the

1 patient be able to afford it?

2 MR. KNEPPER: Objection, form.

3 A. May I say, of course?

4 Q. You may. You may say anything you  
5 would like.

6 A. Of course.

7 Q. Thank you. Well, anything you  
8 would like within reason.

9 If you make a letter of authorization for  
10 a patient for the treatment of gender dysphoria  
11 specifically related to a surgical treatment,  
12 do you think it is good that they be able to  
13 access that treatment that you've authorized?

14 MR. KNEPPER: Objection, form.

15 A. Not to be cagey, I want to talk  
16 about one word you just used in that sentence.  
17 I need you to understand that historically in  
18 our clinic for those 47 years, our clinics  
19 for 47 years, we are not in the business and we  
20 have never been in the business of recommending  
21 surgery or recommending hormones. We recommend  
22 a continued evaluation so that we -- the person  
23 can make up their mind how to proceed.

24 It is not our knowledge base to know  
25 who's going to do better and who's going to do

1 worse and who is not going to have any  
2 difference at all with hormones or with  
3 surgery. So what we do is we say, we will  
4 write a letter of support for endocrine  
5 treatment or for hormones if this is what you  
6 want. And we say what our concerns are. We  
7 tell the endocrinologist and we tell the  
8 surgeon what our concerns are and that we  
9 see -- we have reservations about this, and  
10 these are our reservations, but the patient has  
11 decided this is what he or she wants to do.

12 And so we write a letter of support, but  
13 I don't -- every time you use the word,  
14 "Recommendation," there's part of me that wants  
15 to say, no, we do not recommend. We have never  
16 recommended. We have not had the knowledge  
17 base. We have not had the clinical experience  
18 and the knowledge base to say, I'm a doctor. I  
19 know this field. This is what I recommend to  
20 make you better. We do not talk that way. We  
21 do not think that way. And so I may want to  
22 always put an asterisk to any sentence that you  
23 use the word, "Recommend." I need you to  
24 understand that that's where I'm coming from.

25 MR. CHARLES: Thank you,

1 Dr. Levine.

2 Excuse me just a moment. Can you read  
3 back my question. I don't recall if I used,  
4 "Recommend." I thought I used,  
5 "Authorization." I just want to make sure.

6 (Record was read.)

7 MR. CHARLES: If we could just go  
8 off the record for a second.

9 VIDEOGRAPHER: Off the record 10:52.

10 (Discussion held off the record.)

11 VIDEOGRAPHER: On the record 10:53.

12 BY MR. CHARLES:

13 Q. Okay. Thank you for that  
14 clarification, Dr. Levine. I'll be more  
15 careful about using terminology more close to,  
16 "Authorization," rather than, "Recommendation,"  
17 and I understand your distinction in your  
18 practice. So do you, though, think it's good,  
19 if you are authorizing a treatment, a patient  
20 has said, This is the treatment I would like,  
21 and you have done an evaluation and determined  
22 that you will write, as you said, a letter of  
23 support, do you then, as a practitioner, think  
24 it's good that they can access it, that they  
25 can afford it?

1 concept of agency and being a doctor, I think  
2 is different than the implication of your  
3 question.

4 Q. Is the worrisomeness for a  
5 patient's future health, is that a reason to  
6 deny all medical care for gender dysphoria?

7 A. Absolutely not.

8 Q. Dr. Levine, I'd like to return back  
9 to, I believe it's Exhibit 2, the Claire  
10 deposition. And please, if you would turn to  
11 page 156.

12 A. I'm sorry. 150 what?

13 Q. Page 156. And beginning at line 10  
14 on page 156, Dr. Levine, I'll read it, if  
15 you'll just follow along, please.

16 Question: "Are you aware that this case  
17 concerns an insurance exclusion that is  
18 categorical at preventing" --

19 Skipping to line 15.

20 "-- hormones and surgery as a treatment  
21 for gender dysphoria?"

22 Answer: "I am aware that your plaintiffs  
23 are suing to get coverage for -- that is not  
24 provided by their particular insurance. I am  
25 aware of that."

1 demonstrate their efficacy. This is the  
2 problem.

3 This is the essence of the problem. This  
4 is, I think the essence of my testimony with  
5 you today. It's not whether I personally as a  
6 doctor would like this patient to have  
7 insurance to cover their hormones. It's about,  
8 is this the right thing to do for this person  
9 and can I help the person see clearly what the  
10 dangers are and what the benefits are. That's  
11 the issue for a doctor, for Stephen Levine as a  
12 doctor. I hope that's a cogent answer --

13 Q. It is --

14 A. -- to your question.

15 Q. -- it is cogent. Thank you.

16 Given all of that, is that -- so you just  
17 explained, testified that there are  
18 complications, some lack of -- and I'm  
19 summarizing here, so I will confirm that this  
20 is an accurate summary of what you just shared,  
21 but I can't possibly repeat all of that. Given  
22 all of those concerns that you have, is that a  
23 reason to deny all medical interventions to  
24 people with gender dysphoria?

25 MR. KNEPPER: Objection, form.

1           A.       No, but that's not -- that's a  
2       separate question about insurance.

3           Q.       Yes, it is a separate question. So  
4       now I'm asking: Are those concerns you raised  
5       justifications in your mind for denying medical  
6       interventions to all people with gender  
7       dysphoria?

8                   MR. KNEPPER: Objection, form.

9           A.       You know, I'm not advocating  
10      denying endocrine treatment or surgical  
11      treatment. I'm just saying that we as a  
12      medical profession need to walk the walk that  
13      we talk. We say as a principle of ethics that  
14      our interventions should be based upon the best  
15      current knowledge, it should be based on  
16      science. It should not be based on politics.  
17      It should not be based on fashion. It should  
18      not be based on civil rights considerations.  
19      They should be based on the kinds of studies  
20      that I just described to you with predetermined  
21      outcome majors that are agreed upon --

22           Q.       Sorry?

23           A.       -- period.

24           Q.       I was --

25           A.       I forgot to put the period.

1           Q.     That's okay. Did you just say,  
2     Dr. Levine, you're not an expert in health  
3     insurance?

4           A.     I am not an expert in health  
5     insurance.

6           Q.     Okay. Or what insurance should or  
7     should not cover?

8           A.     Yes.

9           Q.     Do you recall what the insurance  
10    billing code typically is for psychotherapy for  
11    gender dysphoria? I know it's been a long time  
12    since you've accepted commercial insurance, so  
13    I'm not sure if the billing codes are the same,  
14    but do you recall --

15          A.     The billing code is 90837.

16          Q.     Okay. Is there a code that you're  
17    familiar with that is F64.0?

18          A.     That's not a billing -- that's  
19    diagnostic code --

20          Q.     Thank you.

21          A.     -- there's a separate code for  
22    diagnosis and a separate code for procedure.

23          Q.     I see. So F64.0 is a diagnostic  
24    code?

25          A.     Yes.

1 VIDEOGRAPHER: Off the record 11:26.

2 (Recess taken.)

3 VIDEOGRAPHER: On the record 11:31.

4 BY MR. CHARLES:

5 Q. Okay. Dr. Levine, in your report,  
6 you stated that you had not met with any of the  
7 plaintiffs in this case, correct?

8 A. Yes.

9 Q. Okay. And you have not interviewed  
10 any of the plaintiffs in this case, correct?

11 A. Correct.

12 Q. And so you are not offering any  
13 opinions about the plaintiffs in this case,  
14 correct?

15 A. Correct.

16 Q. Okay. And that would include the  
17 veracity of their experiences of gender  
18 dysphoria, correct?

19 A. Yes, correct.

20 Q. And that would not include the  
21 accuracy of their gender dysphoria diagnoses,  
22 correct?

23 A. Correct.

24 Q. Okay. You're not offering any  
25 opinions about their mental health histories?

1 A. Correct.

2 Q. Nor any of the affects of the  
3 gender affirming treatment they may have  
4 received?

5 A. Correct.

6 Q. Okay. Thank you. Let's return to  
7 your report. I don't know if you have that --

8 A. My report?

9 Q. Yes. You can put away that  
10 document in your hand.

11 So if you would, please, turn to page 6  
12 of your report.

13 Okay. So on page 6, paragraph a. at the  
14 bottom of the page there, Dr. Levine. The  
15 report states that this is one of the opinions  
16 you're offering, which is, "Sex as defined by  
17 biology and reproductive function cannot be  
18 changed. While hormonal and surgical  
19 procedures may enable some individuals to  
20 'pass' as the opposite gender during some or  
21 all of their lives, such procedures carry with  
22 them physical, psychological, and social risks,  
23 and no procedures can enable an individual to  
24 perform the reproductive role of the opposite  
25 sex." Did I read that correctly?

1 methodology and are capable of critically  
2 reviewing the literature. So your statement is  
3 true on the most superficial level, but is  
4 totally incorrect when it comes to scientific  
5 standards of care for issuing guidelines for  
6 the medical profession. So I don't know how to  
7 answer the question. On the surface, the  
8 answer is, yes. And underneath the surface,  
9 the answer is, no.

10 Q. So the International Journal For  
11 Transgender Health is still a peer-reviewed  
12 source, though, right?

13 A. It's peer reviewed by people who  
14 make their living supporting transgender care.

15 Q. But it's still peer reviewed,  
16 right?

17 A. It's peer reviewed --

18 Q. And as for your --

19 A. -- I think it's peer reviewed.

20 Q. Okay. Understood. And as for your  
21 more conservative approach, can you cite to any  
22 studies or research that resulted in better  
23 outcomes than people who adhere strictly to the  
24 WPATH standards of care version 7?

25 A. No. This is part of the problem in

1 evaluation leading to a therapeutic process, it  
2 seems prudent, given the fact that we are  
3 changing people's bodies, especially teenagers'  
4 bodies, and they are not of developmental  
5 sophistication yet that court systems or at  
6 least one court system thinks they're certainly  
7 too young to make these life-altering  
8 decisions. So people in SEGM are biased in the  
9 direction of being conservative and providing  
10 psychotherapeutic evaluations of the child, of  
11 the teenager and of their parents, of their  
12 family systems to see if we can find a way to  
13 help them be informed about what is going --  
14 what they think they want to do in their  
15 future.

16 Q. And so when you provide letters of  
17 authorization for hormones or for surgery, do  
18 you do so in accordance with the WPATH  
19 standards of care?

20 A. Yes. That is the standard, to  
21 provide a letter of recommendation.

22 Q. Okay. So turning back to your  
23 report, Dr. Levine. You can go ahead and put  
24 away the trial transcript there.

25 A. I'm sorry. Did you say, "Turning

1           Q.     Okay. So is a, "Hypothesis," an  
2     idea about why something happens, but doesn't  
3     provide evidence for why something is  
4     happening?

5                     MR. KNEPPER: Objection, form.

6           A.     A, "Hypothesis," generates the  
7     pursuit of evidence.

8           Q.     Has social contagion as an  
9     explanation for increased cases of gender  
10    dysphoria been scientifically proven yet?

11          A.     No. But when you seek -- when you  
12    see -- actually see patients and talk to them  
13    about their friends and hear about the  
14    influence of the Internet and the gurus on the  
15    Internet who tell 13 and 12-year-old children  
16    who are concerned about menses or concerned  
17    about breast development or concerned about  
18    their bodies changing and then they're told  
19    that they're transsexual by somebody that  
20    they've never met that they talked to on the  
21    Internet, that would be social contagion or  
22    social education.

23                   Or when you hear about a friend who  
24    declares themselves trans and then your patient  
25    six months later declares themselves trans, you

1 wonder about the -- the interpersonal,  
2 psychological link between best friends in  
3 young puberty, young years of puberty and how  
4 one can identify with one's friends and that  
5 would be a social contagion. Those are 3the  
6 kinds of ideas that people like me get when we  
7 sit with people week after week talking about  
8 their lives. You see, that's not science.

9 But that is clinician and this is the  
10 kind of thing that leads to intuition, clinical  
11 intuition and that's the source of the  
12 generation of the hypothesis. But we think as  
13 clinicians, when we hear -- I mean, I don't  
14 think I've ever seen a teenager trans person  
15 who hasn't been heavily involved and influenced  
16 by the Internet, for example, but I have not  
17 done studies to document that in a way that  
18 would be scientifically acceptable. There are  
19 other people who have.

20 And I doubt very much if you'll ever find  
21 a clinician on any side of this issue, you see,  
22 who would say, oh, no most of my patients have  
23 never talked to anyone on the Internet about  
24 transgender. The Internet is just part of life  
25 today and -- but transgender teenagers spend

1 hours and hours of their time getting counseled  
2 or participating with the virtual trans  
3 community. That's a hypothesis.

4 Q. So no scientific citation?

5 A. When we use the word, "Scientific,"  
6 in the best sense, yes, the answer to your  
7 question is, no scientific.

8 Q. Okay. No studies of citations you  
9 can point to today to support that hypothesis?

10 A. Oh, I think Lisa Littman's studies  
11 are in the literature and/or in press that  
12 documents this.

13 - - - - -

14 (Thereupon, Deposition Exhibit 7,  
15 "Correction: Parent reports of  
16 adolescents and young adults  
17 perceived to show signs of a rapid  
18 onset of gender dysphoria," Article,  
19 was marked for purposes of  
20 identification.)

21 - - - - -

22 Q. Okay. For the record, please note  
23 I'm showing to Dr. Levine what has been marked  
24 as Exhibit 7. "Correction: Parent reports of  
25 adolescents and young adults perceived to show

1 signs of a rapid onset of gender dysphoria," by  
2 Lisa Littman published March 19, 2019. Have  
3 you seen this material before, Dr. Levine?

4 A. I've seen of it. I don't think  
5 I've read it.

6 Q. Okay. Were you aware that the Lisa  
7 Littman article had to be withdrawn, corrected  
8 and republished?

9 A. Yes.

10 Q. Okay. And were you aware that the  
11 initial article was based on a survey of  
12 parents --

13 A. Yes.

14 Q. -- of purportedly transgender  
15 children and the parents were recorded -- I'm  
16 sorry. Let me start over. Were you aware that  
17 the Littman article was based on a survey of  
18 parents who were recruited through some parent  
19 groups?

20 MR. KNEPPER: Objection, form.

21 A. I knew it was a survey of parents.

22 Q. Okay. And did you know there were  
23 no report-outs from the young adults of those  
24 parents in the article?

25 A. It was a report of parents'

1       transitioning. However, it is...important to  
2       note that there are other survey items where  
3       the parent would have direct access to  
4       information about their child and that those  
5       answers reflect items that can be directly  
6       observed." Did I read that correctly?

7             A.       Yes, you did.

8             Q.       All right. Your report also cites  
9       as support for the social contagion hypothesis  
10       to an article from Medscape.com written by  
11       Becky McCall and Lisa Nainggolan as support for  
12       the social contagion theory. Is that correct?  
13       I'm sorry. It's not going to be on this  
14       article, Doctor.

15            A.       I don't know that article.

16            Q.       Okay.

17            A.       You haven't asked me a question  
18       about this. Did I misunderstand something?

19            Q.       No, no. Sorry. We're just --

20            A.       You haven't asked my opinions about  
21       that, yeah.

22                    - - - - -

23                    (Thereupon, Deposition Exhibit 8,  
24                    "Transgender Teens: Is the Tide  
25                    Starting To Turn?" Article, was

1 marked for purposes of  
2 identification.)

3 - - - - -

4 Q. Yeah. So, for the record, I'm  
5 showing Dr. Levine what has been marked as  
6 Exhibit 8. "Transgender Teens: Is the Tide  
7 Starting To Turn?" by Becky McCall and Lisa  
8 Nainggolan, April 26, 2021. Dr. Levine, you  
9 said you have not reviewed this article before?

10 A. Which one are you referring to?

11 Q. I'm sorry. That one to your left.

12 A. This?

13 Q. Yes. Take your time.

14 A. Have I reviewed it, no. You know,  
15 I've seen the picture of Keira Bell. I've seen  
16 news reports of this in the past, but they were  
17 just news reports, yeah.

18 Q. Do you know if either of the  
19 authors of this article is a scientist?

20 A. I have no idea.

21 Q. Okay. Or a psychiatrist?

22 A. (Indicating.)

23 Q. I'm sorry. Could you make your  
24 responses verbal? I'm forgetting.

25 A. I have no idea.

1           Q.     Okay. Thank you. Have either of  
2           them ever treated transgender children or  
3           adolescents?

4           A.     I would have no idea.

5           Q.     Okay. To your knowledge, is the  
6           information provided on Medscape.CA subject to  
7           peer review?

8           A.     I don't know how Medscape works.  
9           I've heard there have been retractions, but I  
10          don't know how their peer reviewed is made.  
11          Perhaps people write in that, This is  
12          ridiculous what you've been teaching or what  
13          you've been saying, but whether they're peer  
14          reviewed or not, I have no idea.

15          Q.     So you probably -- I'm sorry. So  
16          do you know if this article has been published  
17          in a peer-reviewed journal to your knowledge?

18          A.     "Transgender teens: Is the  
19          Tides" -- that article?

20          Q.     Yes.

21          A.     I don't know. I don't know this  
22          article. I don't know where it's from.

23          Q.     Okay. So your report includes a  
24          quotation from this article. "The vast  
25          majority of youth now presenting with gender

1 multi-continental set of observations from  
2 Europe, from Australia, from North America --

3 Q. Okay.

4 A. -- it almost doesn't even need  
5 citations it's so clinically apparent.

6 Q. Okay. But there's no citation in  
7 your report?

8 A. In my report, yes.

9 Q. Okay. So on page 18, going back to  
10 your report, at the bottom of page 18, you use  
11 a term, "Transgender Treatment Industry." Is  
12 this the first time you have used this term?

13 A. In this report?

14 Q. No.

15 A. You mean, did I ever use it in  
16 another report?

17 Q. Yeah, yeah.

18 A. I'm not sure. If this is -- if  
19 it's not the first, it might be the second.

20 Q. And where did the term originate?

21 A. I think it -- the term originated  
22 from Dwight Eisenhower at the end of his --  
23 when he was leaving the presidency in 1952, he  
24 warned the people about the military industrial  
25 complex and that there was a very comfortable

1 the methods we made reference to before, the  
2 efficacy of the treatment and the downsides of  
3 the treatment. But because WPATH is an  
4 advocacy organization and the scientific  
5 establishment of the efficacy of their  
6 treatments are not important to them, what they  
7 are doing is teaching young mental health  
8 professionals and medical professionals as a  
9 whole what their ideology is. They say it's  
10 scientifically established.

11 I'm here to tell you to the extent that I  
12 understand science, it is not scientifically  
13 established. In a sense, there is an industry  
14 that has different elements that feed each  
15 other; that's the transgender treatment  
16 industry. I think if we put our heads  
17 together, we could find another term.

18 Q. So did you coin that phrase then?

19 A. No --

20 Q. Okay.

21 A. -- no.

22 Q. Have you seen it used before in any  
23 peer-reviewed articles?

24 A. Not in a peer-reviewed article.  
25 I've seen it used in these kind of expert

1 opinion -- (Indicating.)

2 Q. Okay.

3 A. -- I would -- you know, if I had  
4 time and I had a committee of people, I -- I  
5 would probably find a different term for it.  
6 But I don't mean it in a disparaging way. I  
7 mean that this is a group of compassionate  
8 people trying to help other people who actually  
9 believe that the science has established the  
10 best practices when in fact they're not well  
11 informed.

12 Q. Do you need a sip of water after  
13 that?

14 A. No. I'm just a long-winded guy.

15 I want to add, if I may, that we should  
16 make a distinction between education and  
17 indoctrination. Education can be based on  
18 science. Indoctrination is based on preferred  
19 beliefs that, if you allow me to use this term  
20 again. The transgender treatment industry is  
21 heavy on indoctrination and has declared, if  
22 you look at the standards of care, if you don't  
23 believe these systems, you're not a  
24 competent -- you're not competent to take care  
25 of people. That of course is the height of

1           A.     No. Their gender dysphoria may be  
2     a product, you see, of these other things. For  
3     example, if you have someone who has been  
4     sexually abused by her stepfather and becomes a  
5     trans person in adolescents, we want to talk  
6     about the sexual abuse and the process between  
7     that person and what fears for the present and  
8     the future that has caused the child. And  
9     we're not attacking their trans identity.  
10    We're trying to help them understand where they  
11    came from and what they're coping with and why  
12    they're so fearful or so distressed by their  
13    body changing.

14           Q.     And their gender dysphoria could be  
15    separate and apart from that traumatic  
16    experience?

17           A.     Theoretically it could be, yes.

18           Q.     And if it persisted sufficiently  
19    enough, you would consider a letter of  
20    authorization for --

21           A.     Yes.

22           Q.     -- hormones?

23           A.     Yes.

24           MR. KNEPPER: Objection, form.

25           Q.     Okay. If you would, please, turn

1           A.       That is correct. And may I add  
2       that it's very, very difficult to understand.  
3       The natural question would be, how do you  
4       compare the general population with the trans  
5       people who did not have surgery with the trans  
6       people who did have surgery.

7           Q.       Thank you, Dr. Levine. That's not  
8       my question, though. I just wanted to confirm  
9       that was not the control group. You mentioned  
10      this study later in your report, page 66  
11      beginning at paragraph 74. Do you see that?

12          A.       Um-hum.

13          Q.       Okay. And basically that -- well,  
14      here, let me point you exactly. The sentence  
15      starts with, "Similarly," about halfway down  
16      the page, third sentence of that paragraph.

17          A.       Um-hum.

18          Q.       And, as you mentioned, you cite the  
19      Dhejne study and I believe -- or I should ask:  
20      Is the Denmark study you're referencing the  
21      study directly after it --

22          A.       The Simonsen study.

23          Q.       -- the Simonsen study?

24          A.       Yes.

25          Q.       Okay. So beginning with the Dhejne

1 study, do you think because that study showed  
2 that some people committed suicide after gender  
3 affirming surgery that no patient should be  
4 able to access gender affirming surgery?

5 MR. KNEPPER: Objection, form.

6 A. That would be illogical.

7 Q. Okay. Dr. Levine, I understand you  
8 said that would be illogical, but just to be  
9 clear. You're not recommending -- sorry. I'm  
10 not using that word. You're not saying that  
11 the fact that some people commit suicide  
12 following gender affirming surgery means that  
13 there should be a ban on access to that  
14 surgery. Is that right?

15 A. Not for that reason, no.

16 MR. KNEPPER: Objection, form.

17 Q. Not for that reason. Okay. Are  
18 you recommending that there would be bans on  
19 gender affirming surgery for any reason?

20 A. I think there are -- you know, I  
21 think most prudent people in this field, just  
22 to use the example of what you read out loud  
23 about the Finland study, a case-by-case basis.  
24 That's how doctor need to decide things, but  
25 there are many, many reasons to be cautious

1 fashion and to be very hesitant about going  
2 forward.

3 Q. But you're not recommending total  
4 bans on gender affirming surgery?

5 A. I'm not recommending total bans.  
6 I'm aware of the individual circumstances of  
7 individual people's lives and their commitment  
8 to transgender living. And I don't want to be  
9 draconian about this. I want to be  
10 compassionate about this.

11 Q. I understand. I appreciate that.  
12 I just want to make sure I'm understanding you  
13 correctly.

14 - - - - -

15 (Thereupon, Deposition Exhibit 12,  
16 "Long-Term Follow-Up of Transsexual  
17 Persons Undergoing Sex Reassignment  
18 Surgery: Cohort Study in Sweden,"  
19 Article, was marked for purposes of  
20 identification.)

21 - - - - -

22 Q. So for the record, I'm presenting  
23 to Dr. Levine what has been marked as  
24 Exhibit 12. "Long-Term Follow-Up of  
25 Transsexual Persons Undergoing Sex Reassignment

1           For the 22nd time today, did I read that  
2           correctly?

3           A.     It's the 23rd time.

4           Q.     Oh, okay.

5           A.     Yes.

6           Q.     I was hoping you weren't counting,  
7           but, okay. Did you testify earlier today that  
8           the limitation of the Dhejne study is that the  
9           controls were not transgender persons who had  
10          not undergone gender affirming surgery?

11          A.     Yes.

12                   MR. KNEPPER: Objection, form.

13          Q.     Okay. You can set that aside,  
14          Dr. Levine.

15                   - - - - -

16                   (Thereupon, Deposition Exhibit 13,  
17                   2017 "On Gender Dysphoria," Booklet  
18                   From Department of Clinical  
19                   Neuroscience, Karolinska Institutet,  
20                   Stockholm, Sweden, was marked for  
21                   purposes of identification.)

22                   - - - - -

23          Q.     For the record, Dr. Levine has an  
24          exhibit that has been marked as Exhibit 13.  
25          "On Gender Dysphoria," by Cecilia Dhejne from

1 ideation in transgender people.

2 A. Well, you know about the  
3 Branstrom-Pachankis study and the criticism of  
4 the study --

5 Q. But I'm not talking about the  
6 study.

7 A. -- and part of the study  
8 demonstrated that it increased suicidal  
9 ideation and attempts in the first two and a  
10 half years after surgery, especially in the  
11 first year --

12 Q. Right. Is your testimony --

13 A. -- so I'm not testifying that. I  
14 thought you were asking me about this, which I  
15 need to comment on, because this is not an  
16 accurate depiction of my statement in the  
17 reference. (Indicating.)

18 Q. Well, that's not what I'm asking  
19 about, Dr. Levine.

20 A. Well, you're reading this and I'm  
21 misquoted here. So I don't want you to imply  
22 that she is accurately representing my views,  
23 because I did not say that gender affirming  
24 treatment in general should be stopped. I've  
25 never said that. This is an article about

1 at different times have reported that in the  
2 large majority of patients, absent a  
3 substantial intervention such as social  
4 transition and/or hormone therapy, gender  
5 dysphoria does not," continue, "through  
6 puberty."

7 So there are some children who persist in  
8 their asserted gender identity through puberty,  
9 correct?

10 MR. KNEPPER: Objection, form.

11 A. Correct.

12 Q. And some who persist in wanting to  
13 transition via medical treatments?

14 MR. KNEPPER: Objection, form.

15 A. Yes. Some of the children have  
16 learned about medical treatments somewhere  
17 along the line and they feel instantly that  
18 this is for them.

19 Q. And then looking at paragraph 56,  
20 which is on page 41, so just the very next page  
21 on the bottom, the second sentence in that  
22 paragraph. "I observe an increasingly vocal  
23 online community of young women who have  
24 reclaimed a female identity after claiming a  
25 male...identity at some point during their teen

1 transgender people is individual based, right?

2 A. Well, it's both --

3 MR. KNEPPER: Objection, form.

4 A. -- yes, that's partially true. And  
5 ideally that's true, but it's obviously not  
6 entirely true. It's why we're here, is it's  
7 categorically based.

8 Q. Let me rephrase that. You design  
9 treatment for your patients based on what that  
10 patient in front of you, what they need, what  
11 they want, what you determine -- sorry. Not  
12 what you determine, but what you might  
13 authorize?

14 MR. KNEPPER: Objection, form.

15 A. What the patient and I discern  
16 together.

17 Q. Thank you. Okay. Let's jump to,  
18 again, still in your report, page 68.

19 A. We've left 40 and 41? 68.

20 Q. Okay. Looking at the bottom of  
21 page 68, Dr. Levine, paragraph 78. It states,  
22 "Similarly, the American Psychological  
23 Association has stated because approach" --

24 A. Sorry.

25 Q. I apologize.

1 Gender Nonconforming People (2015)."

2 So is that lack of consensus that you  
3 discuss a justification to categorically ban  
4 social transition for children as a treatment  
5 for gender dysphoria?

6 MR. KNEPPER: Objection, form.

7 A. By, "Children," you mean 6 and 7  
8 year olds?

9 Q. Those for whom medical intervention  
10 is not indicated.

11 A. Is that a reason to ban it?

12 Q. Correct, social transition.

13 MR. KNEPPER: Objection, form.

14 A. The reason to -- so let me qualify  
15 that. There's a, yes, answer, there's a reason  
16 to ban it. And the reason to ban it is both a  
17 developmental and an ethical reason. There  
18 have been eleven studies of these cross-gender  
19 identity children who are not socially  
20 transitioned and the vast majority of them  
21 de-transition by the time they're mid  
22 adolescents or older adolescents. They become  
23 homosexual individuals usually or bisexual  
24 individuals, but they are cis gender.

25 So if we take a 6-year-old child and

1           A.     -- nor you didn't ask me to comment  
2     on that.

3           Q.     It was related to what you had said  
4     before. So this is related but not related to  
5     what we just read. So you can put that aside.

6           A.     Okay. But your next question was  
7     about puberty blocking hormones, which are not  
8     being used for 6-year-old's and 7-year-old's --

9           Q.     Correct, yes, a separate group of  
10    people.

11          A.     -- so we're on a different  
12    category.

13          Q.     Yes.

14          A.     Okay. So you asked me if I think  
15    puberty blocking hormones should be used on a  
16    case-by-case basis?

17          Q.     Correct, yes.

18          A.     I don't think so.

19          Q.     So that is to say, there are no  
20    circumstances you would advocate for a total  
21    ban on that intervention?

22                 MR. KNEPPER: Objection, form.

23          A.     Number one, I've never seen a child  
24    where that has come up where I thought it was a  
25    good idea. In the cases I've seen, it was like

1 a treatment for the mother's pathology, not for  
2 the child. And it's like a warning sign, boy,  
3 be careful. You see, if you see one case like  
4 that, you wonder -- and it's so conspicuous,  
5 you wonder in the next case, if the same thing  
6 is going on in a more subtle way.

7 Is the child acting out the ambitions of  
8 the mother or the father? I just think  
9 prudence -- I think considering the child has  
10 not gone through puberty or has not gone far  
11 into puberty and puberty brings all kind of  
12 psychological, physical and social changes to a  
13 child and those changes lead to desistance in  
14 many, many children, to put them into a state  
15 where all their peers are developing physically  
16 and they're going to be poirot (phonetic).

17 And then most of those children have  
18 social anxiety problems and they avoid -- they  
19 don't have friends, right. And this is going  
20 to make them even more different than their  
21 peers and it's gone to deprive them of the  
22 sexualization of their mind and the discovery  
23 of masturbation and the discovery of sexual  
24 desire for partners, you see. This is only  
25 going to increase the child's difference from

1 her peers or his peers and I don't think this  
2 is a prudent idea.

3 And if you wanted me to suggest a ban on  
4 anything, it would be a ban on using puberty  
5 blocking hormones, especially when the  
6 evaluation of those children are focused on the  
7 gender dysphoria of the child and not on the  
8 background of the child and not on what's going  
9 on. So I think that's an answer to your  
10 question.

11 If we're going to use these drugs, if  
12 we're going to use social transformation of  
13 children, if we're going to use puberty  
14 blocking hormones, it should only be used in a  
15 carefully designed protocol. And follow up has  
16 to be guaranteed so in one year and in two  
17 years and in three years and before we start  
18 giving cross-gender hormones we have data --

19 Q. Sorry.

20 A. -- so the answer to your question  
21 is, I would consider banning puberty blocking  
22 hormones even for children who have been  
23 cross-gender identified for four years to give  
24 them a chance to desist, which is exactly what  
25 the Dutch protocol did, by the way.

1           Q.     Sorry. So you just said you would  
2     ban -- you would recommend a ban on --

3           A.     If --

4                     MR. KNEPPER: Objection, form.

5           A.     -- look, I'm a doctor. I'm not a  
6     policy maker --

7           Q.     I understand, yes.

8           A.     -- if you ask me my political  
9     opinion about, should we ban this, is that a  
10    reasonable thing, I think there's a very strong  
11    argument for banning puberty blocking hormones.

12          Q.     Okay. And, right. So you're here  
13    as an expert offering an expert opinion. So  
14    are you separating that from -- like are you  
15    saying your political views that you would  
16    advocate for bans or are you saying your expert  
17    opinion you're offering in this case is you  
18    would recommend ban?

19                     MR. KNEPPER: Objection, form.

20          A.     I would recommend ban. To what  
21    extent it's from my politics or from my being a  
22    parent or from my being a doctor, I don't know.  
23    I would recommend we not use puberty blocking  
24    hormones.

25          Q.     In Claire, in this case that we

1           Answer: "Where we had a healthy mother  
2           and father, an intact family who was  
3           psychologically informed and who has -- where a  
4           child has come out of toddlerhood acting  
5           consistently in a gender atypical fashion, and  
6           where the parents are not homophobic..."

7           Question: "The parents are not what kind  
8           of people?"

9           Answer: "Homophobic."

10          For the 27th time, did I read that  
11          correctly? Did I read that correctly?

12          A.       Yes.

13          MR. CHARLES: Okay. All right.  
14          Let's go ahead and take a break for a few  
15          minutes.

16          VIDEOGRAPHER: Off the record 3:20.

17          (Recess taken.)

18          VIDEOGRAPHER: On the record 3:38.

19          BY MR. CHARLES:

20          Q.       So, Dr. Levine, before the break,  
21          you were talking about 6 and 7 year olds and  
22          you mentioned there were eleven studies. Can  
23          you identify which eleven studies from your  
24          report you're referring to?

25          A.       Cantor, the reference Cantor lists

1 the eleven studies and these eleven studies  
2 have been done over probably thirty years.

3 Q. Okay. So Cantor was one review of  
4 eleven studies?

5 A. Cantor was a review of the eleven  
6 studies. I can't list to you the eleven  
7 individual studies. The latest one is written  
8 by Singh, S-i-n-g-h. It was published in April  
9 of 2021, in the Frontiers of Psychiatry. And  
10 that perhaps is the most comprehensive of them.  
11 And that's the one that confirms -- that's a  
12 study of boys and it confirmed that 12.2, I  
13 think percentage of them persisted over a  
14 thirteen-year period.

15 Q. So that was one -- that was the  
16 Singh study that came out. Is that same study  
17 mentioned in the Cantor review?

18 A. (Nodding.)

19 Q. Okay. And you said that  
20 established that 12.2 percent of prepubertal  
21 boys persisted into adolescents? Okay.

22 A. Yes. This harkens back to the  
23 ethical issue that I talked about before. You  
24 know, if you know that 88 percent of them are  
25 going to persist -- desist, why in the world

1 identified 60,000 case reports world wide on  
2 the Internet. See Exposito-Campos..." --

3 A. That is an error, by the way.

4 Q. Sorry. Which part of that is an  
5 error?

6 A. That, "60,000," is my error. It  
7 should say, "16,000."

8 - - - - -

9 (Thereupon, Deposition Exhibit 17,  
10 "A Typology of Gender Detransition  
11 and Its Implications for Healthcare  
12 Providers," Article, was marked for  
13 purposes of identification.)

14 - - - - -

15 Q. Okay. So for the record, I'm  
16 showing Dr. Levine what has been marked as  
17 Exhibit 17. "A Typology of Gender Detransition  
18 and Its Implications for Healthcare Providers,"  
19 Pablo Exposito-Campos, 2021. Okay. Have you  
20 seen this study before, Dr. Levine?

21 A. Yes.

22 Q. Okay. So on page 1 of this report,  
23 about halfway through the very first paragraph  
24 in the introduction beginning with, "As a  
25 consequence." Do you see that there?

1 important to note that this typology does not  
2 suggest two clear-cut categories, for a  
3 secondary detransition can lead to a primary  
4 detransition" -- oh, sorry. Let me start over.  
5 Sorry.

6 Okay. Let me start from a different  
7 place, Dr. Levine. The second sentence.

8 "In r/detrans" --

9 And there's an HTTP address --

10 A. Okay.

11 Q. Okay. You see that.

12 -- "a subreddit for detransitioners to  
13 share their experiences with more than 16,000  
14 members, one can find several stories of people  
15 who call their transgender status into question  
16 after stopping transitioning due to medical  
17 complications or feeling dissatisfied with  
18 their treatment results"?

19 Do you know what a, "Subreddit," is,  
20 Dr. Levine?

21 A. I believe it's just a division of a  
22 larger website where people, you know, with  
23 similar interests.

24 Q. Okay. Do you understand this  
25 sentence to be suggesting that all 16,000 of

1       those members have offered a story of  
2       detransition?

3                   MR. KNEPPER:  Objection, form.

4           A.       I think -- I think it may be true  
5       that either they have offered a personal story  
6       or they're fascinated because of their own  
7       considerations of that story.  They're thinking  
8       about it themselves, which would be in keeping  
9       with the idea that even people who have  
10      transitioned begin to doubt whether they made a  
11      wise decision and they're considering  
12      detransition.  I'm not so sure it means that  
13      all 16,000.  I would have no way of  
14      ascertaining that.  You know, in my worry, I  
15      would lean towards most of them are seriously  
16      considering or have detransitioned.  And in my  
17      skepticism, I would say I'm not sure whether  
18      it's 15,000 or 12,000 or 8,000.

19           Q.       But you have no way to confirm  
20      that --

21           A.       I have no way.

22           Q.       -- if it's all of them or a few of  
23      them or three of them?

24           A.       You're absolutely right.  I have no  
25      way of confirming that.

1 where hormones are safe and surgery is a good  
2 thing to do. If a person said that, you know,  
3 skeptically, I think that would disappoint  
4 certain patients, but how it was said and when  
5 it was said in response to what would either  
6 determine whether the person is engaged with  
7 the mental health professional or leaves the  
8 mental health professional. You know, all  
9 mental health professionals are not created  
10 equal.

11 Q. So it sounds like you're saying it  
12 could do harm to that patient?

13 MR. KNEPPER: Objection, form.

14 A. No, I'm not saying that. I'm  
15 saying it could be disappointing to that  
16 person. What that person did with the  
17 disappointment may prove harmful just because  
18 of that person or it may prove in fact  
19 beneficial.

20 Q. Are you satisfied -- let's orient  
21 this question around the patients you've seen  
22 in the last 12 months. Are you satisfied that  
23 those patients -- actually, sorry. Let me  
24 start over. Are you satisfied that the  
25 patients you have seen historically for whom

1       you provide letters of authorization for  
2       hormones give sufficiently informed consent?

3               MR. KNEPPER:  Objection, form.

4               A.       From my point of view, I did what I  
5       could to reach the standard of having the  
6       person internalize and think about, digest,  
7       dream about and come back and talk to me about  
8       it.  That's all I can do.  I can't guarantee  
9       that if I do what I do that it's going to  
10      change your mind or help you steer your ship in  
11      a slightly different angle --

12              Q.       So --

13              A.       -- so I would not write a letter of  
14      recommendation if I didn't feel like I did my  
15      part.  And if the person indicated that they  
16      couldn't pay attention to me, I wouldn't write  
17      the letter.

18              MR. CHARLES:  Understood.

19              Okay.  John, finished.

20              MR. KNEPPER:  You're finished?

21              MR. CHARLES:  I mean, barring --

22              MR. KNEPPER:  Barring --

23              MR. CHARLES:  We can't tell the  
24      future.

25              MR. KNEPPER:  I wasn't ready for

1 history and current psychiatric diagnosis, it's  
2 more complicated than just the internet.

3 But we need to understand who these  
4 children are and how they're different from  
5 their peers and what we could possibly do to  
6 help them to have a better life. I know some  
7 of the conversation today was, we'll help them  
8 have a better life by giving them puberty  
9 blocking hormones, but that doesn't address --  
10 I think it has a risk of harming them further.  
11 And it doesn't address the comorbid  
12 developmental challenges that these children  
13 face.

14 And I'm afraid -- and it's controversial,  
15 because I don't have the answer. I'm afraid  
16 there's a possibility we're making these  
17 children have a worse outcome. And until you  
18 can demonstrate to me in a very careful  
19 controlled study that separates the autistic  
20 from the non-autistic, you see? That separates  
21 the kids who come from a family that's intact  
22 from a family where there's a single parent.  
23 Where you can separate the kids who were  
24 sexually abused from the kids who were not  
25 sexually abused. I'm not sure puberty blocking